Lifetime Health & Wellness

A Member of the WellnessOne™ Alliance

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PERSONAL INJURY AUTO ACCIDENT INFORMATION FORM

Your Name:____ Today's Date:____________

Address:_________________________________ City:____________________ Zip:__________

Home Phone:__________________ Work Phone: __________________ S.S. #:_____/____/_______

Birth Date: ___/___/___ Age:_______ Marital Status: S M D W Spouse's Name:_______________

E- Mail Address ______________________ Referred to this office by:________________________

Please Indicate Your Doctor of Preference: □ Any □ Dr. Snyder □ Dr. Bates □ Dr. Pillon

Your Employer:____________________________ City:_________________________________

Your Occupation:____

Type of Job: □ Office Orientated • □ Manual • □ Travel • □ Homemaker

Job Requirements: □ Lifting • □ Bending • □ Stooping • □ Telephone Cradling • □ Typewriting/Data Entry
□ Prolonged Sitting • □ Prolonged Standing • □ Lifting Children,Ages:____________

Your Primary Care Physician: ___________________________________ Phone #: ____________

Date of Accident: ______________ Time: __________ AM □ PM □ •Location: _________________

Have your injuries been reported? Yes □ No □ If yes, to whom: ______________________________

Your Vehicle Year:______ Make:______________ Model:________________ Damage:$__________

Other Vehicle Year:_____ Make:_______________ Model:________________ Damage:$__________

Road Conditions: □ Dry □ Wet □ Icy Other:______________ Traveling or Stopped Facing: N S E W

Accident Was: □ Auto to Auto • □ Auto to Object • □ Pedestrian/Cyclist to Auto • □ Industrial-on Job

Were you the □Driver □ Passenger

History of accident: □ Stopped and Rear-ended □ Hit Head On □ Car Ran A Stop Sign Or Red Light
□ Broadsided □ Side Swiped □ Lost Control Of Car □ Other:______________________

Was Your Car...? □ Slowing Down • □ Speeding Up • □ Steady Speed • □ Stopped

What Direction Were You looking at the time of the accident?(i.e. forward, backward, etc.)______________

Was Your Foot on the Brake? Yes □ No □ • What approximate speed was the other vehicle moving? _____

Were you wearing a seat belt? Yes □ No □ • lap belt □ shoulder + lap belt □

Did your vehicle have a headrest? Yes □ No □ • Was it Up □ or Down □

Did your vehicle have an airbag? Yes □ No □ • Did it deploy? Yes □ No □

Were you aware of the approaching collision? Yes □ No □

Did you strike any objects in the car? Yes □ No □
□ Steering column □ Rearview mirror □ Dash board □ Windshield
□ Headrest □ Seat broke □ Cannot remember □ Other: ________________

What portion of your body did you strike?
□ Head □ Chest □ Face □ Knees □ Arms □ Other If so, where? ________________

Were you rendered unconscious? Yes □ No □ If so, how long? __________________________

Accident Scene:Did the police come? Yes □ No □

Were you taken to the hospital? Yes □ No □ Were you seen in the emergency room? Yes □ No □

If yes, how? □ by ambulance □ by friend
□ drove yourself □ went home and later was taken or drove
□ name of hospital:_______________________ City _________________________

What was done? ☐ Examination ☐ Stitches ☐ X-rays
☐ Physiotherapy ☐ Cervical collar ☐ Complete bed rest
☐ Prescription ☐ Other:___________________________________

After your release, what did you do? ☐ Return home to bed ☐ Return to work
☐ Other:____

Have you seen other doctors and been treated as a result of this accident? Yes ☐ No ☐
If yes, please list names and specialties: ____
____
____

What did the other doctor(s) do? ☐ Examination ☐ Injections ☐ X-rays
☐ Prescriptons ☐ Traction
☐ Physiotherapy: how long:_________________________________
☐ Other:____

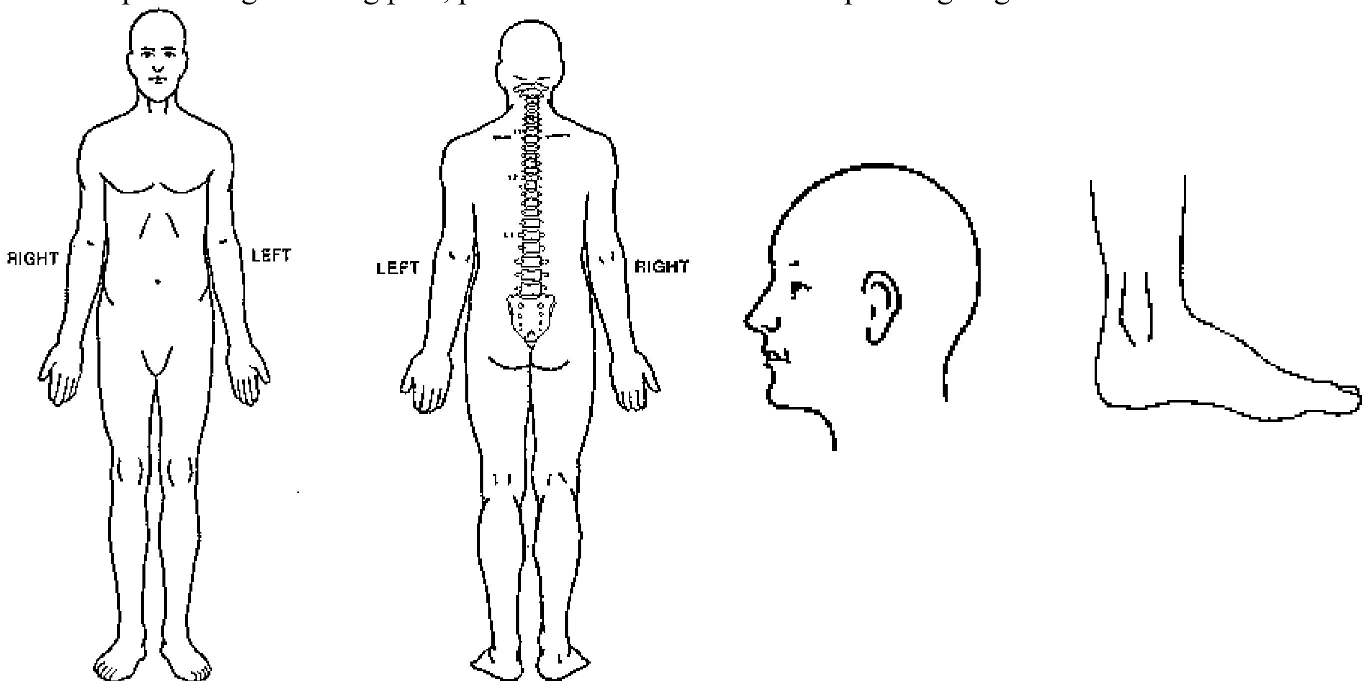
How long have you been under the care of a physician? _________________________________
We would ask your assistance in obtaining copies of your records.
Are you still under their care? Yes ☐ No ☐

Tell Us What Is Bothering You

In order to give the doctor a clear understanding of your case, we would like you to answer a few simple questions. Please be as specific as possible on both the body diagrams and the questions. If you are unsure about any part of this form, please feel free to ask the staff, or especially the doctor.

What is your main area of chief complaint? (i.e. neck pain, headaches, low back pain, arm/leg pain)
____
____
____

Please ***mark*** the appropriate area of your chief complaint on the following diagrams. If you are experiencing radiating pain, please mark the areas that the pain is going to.



Please check the following symptoms which apply to your condition *following* the accident:

☐ Headache	☐ Depression	☐ Neck pain	☐ Neck stiffness
☐ Insomnia	☐ Irritability	☐ Tension	☐ Loss of taste
☐ Diarrhea	☐ Anxiety	☐ Fainting	☐ Loss of smell
☐ Chest pain	☐ Constipation	☐ Dizziness	☐ Loss of memory
☐ Eye strain	☐ Double vision	☐ Pain behind eyes	☐ Ringing in ears
☐ Face flushed	☐ Pallor	☐ Shortness of breath	☐ Pain upon rising
☐ Tremors	☐ Palpitations	☐ Nausea or vomiting	☐ Muscle jerking
☐ Sore muscles	☐ Pain in joints	☐ Leg problems	☐ Extreme fatigue
☐ Loss of feeling	☐ Feet cold	☐ Hands cold	☐ Swelling
☐ Mental dullness	☐ Sinus trouble	☐ Extreme nervousness	

☐ Excessive sweat ☐ Digestive disorders ☐ Difficulty in prolonged sitting

☐ Back pain or stiffness: ☐ Upper ☐ Mid ☐ Lower

☐ Pain radiating into: ☐ Arms ☐ Buttock ☐ Legs ☐ Feet

☐ Head seems too heavy ☐ Head and shoulders feel tired

☐ Restriction of motion: ☐ Neck ☐ Upper back ☐ Low back

Numbness in: ☐ Neck R/L ☐ Shoulders R/L ☐ Arms R/L
☐ Fingers R/L ☐ Hips R/L ☐ Legs R/L ☐ Feet R/L

Pins and needles in: ☐ Neck R/L ☐ Shoulders R/L ☐ Arms R/L
☐ Fingers R/L ☐ Hips R/L ☐ Legs R/L ☐ Feet R/L

Any other condition not specified: ____

What factors aggravate your complaint?(Make you worse)

____ Sitting for long periods of time ____ Standing for long periods of time

____ Walking Getting up and down out of chair/car ____ Driving

Lifting:	____ Light	____ Moderate	____ Heavy	____ Repeated
Twisting:	____ Light	____ Moderate	____ Heavy	____ Repeated
Standing:	____ Light	____ Moderate	____ Heavy	____ Repeated

____ Other activities (please list) ____

Check any of the following that have helped you get relief from your complaint.

____ Ice ____ Heat ____ Stretches/exercise

____ Rest ____ Massage ____ Other (please list):____________________

____ Medication(Please List): ____

Does your pain seem to be worse at any of the following times of day?

____ Worse when I wake up ____ Worse in the afternoon ____ Worse in the evening

____ Wakes me up at night ____ Worse only with activity ____ Constant, no relief

____ Other (please list) ____

Are there any activities you cannot do because of your condition?

____ Work ____ Clean house ____ Drive

____ Lift things ____ Play sport/activity

____ Other (please list) ______________________________

Does your pain seem to be getting: ____ Same ____ Better ____ Worse

Were any of the above symptoms present immediately prior to the accident? ☐ Yes ☐ No

HISTORY:

Auto Accident: ____________________

Serious Fall: ____________________

Hospitalizations: ____________________

Surgeries: ____________________

Emotional Upsets: ____________________

Recent Dr. Visits: ____________________

Date of Last: Physical Exam Spinal X-Ray Spinal Exam
Chest X-Ray Blood Test Dental X-Ray
Urine Test

Do you take: o Nerve pills o Muscle relaxers o Pain killers o "Pep" pills
o Tranquilizers o Insulin o Birth control o Other: ______________

Do you now take vitamins and/or minerals?: o Yes o No If yes, list: ____________________

Habits (please give amount):
o Tobacco _____ (packs/day) o Alcohol ______ (drinks/day)
o Caffeine (coffee/tea/cola) ______ (drinks/day) o Non-job exercise _____ (hrs/wk)
o Sleep _____ (hrs/night) o Do you sleep on your: o Back o Side o Stomach
o Do you use a bedboard? o Yes o No Is your bed comfortable? o Yes o No

Do you wear: o Heel lifts o Sole lifts o Inner soles o Arch supports o Back brace o Prescribed orthotics

Mark the following diseases you have had:
o AIDS/HIV o Heart Disease o Rheumatoid Arthritis o Anemia
o Hepatitis o A o B o C o Rheumatic fever o Cancer/Tumors o Malaria
o Small pox o Chicken Pox o Measles o Tuberculosis
o Diabetes o Multiple Sclerosis o Typhoid Fever o Diphtheria
o Mumps o Whooping Cough o Eczema o Pneumonia
o Polio o Epilepsy o Other: _____________

Are you aware of any diseases that run in your family? o Yes o No If yes, describe: ____________________

Do any family members have similar health problems? o Yes o No (If yes, please describe):

FOR WOMEN ONLY:

Date of your last normal period: ____________________ ***Interval between periods: ____days***

First period at age: ____________ **Date of last visit to gynecologist:** ________________________

Is there any chance you may be pregnant? o Yes o No

Check all that apply:
o Irregular cycles o Excessive flow o Congested breasts, lumps in breasts
o Premenstrual tension o Other menstrual symptoms
o Pain or bleeding during o Vaginal discharge
o Cramps or backache o Menopausal symptoms

The best doctor/patient relationship is when there is complete understanding of treatment and financial responsibilities between the doctor and the patient.

Colorado's Automobile Liability laws provide for health care coverage regardless of fault. This means that your insurance company will pay your bill. If your medical bills exceed $2500.00, you then have the option of suing the other party for "pain and suffering" in addition to medical expenses.

If you do not have insurance, you are responsible for payment at the time services are rendered. If you believe that another person's insurance should cover your bill, we strongly recommend you seek legal advice, as the other person's insurance is not automatically responsible for your health care bills.

It is possible the other insurance company will accept responsibility for your bill rather than go to court over the matter. In order for our office to accept insurance assignment in such a case we must obtain a signed authorization from the insurance company to that effect. If proper authorization is supplied to us, we will bill the insurance company for payment for services you receive.

I acknowledge that I have read and understand the above policy.

______________________ ____

Date Signature of Patient or Guardian

______________________ ____

Date Witness

Name Of Your Auto Insurance Company (Not Agent): ______________________________________

Address and Phone # :

____

Insurance Policy # : ____

Your Attorney's Name: ____

Address and Phone # :

____

AUTHORIZATION TO RELEASE INFORMATION & AUTHORIZATION TO PAY PHYSICIAN/LIEN

I hereby authorize Lifetime Health & Wellness, Inc. to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Lifetime Health & Wellness, Inc.; and I hereby release you of any consequences thereof. I also authorize my attorney and/or insurance company to pay by check made out and mailed directly to Lifetime Health & Wellness, Inc. any moneys due, and otherwise payable to me, the same to be deducted from any settlement made on my behalf, for professional services rendered. Further I agree to pay Lifetime Health & Wellness, Inc. the difference, if any, between the total amount of their charges and the amount paid by the attorney and/or insurance carrier. I understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment upon delivery of services unless prior arrangements are made. All patient "co-pays" or non-covered percentage fees are to be paid by the patient following each day's services. I understand that should my account fall delinquent, it may be turned over for collection, I agree to pay the costs of collection, I agree to pay the costs of collection, including reasonable attorney fees. I understand that the collection agency takes 40% of all monies collected, this charge would be passed on to me and added to my outstanding balance. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original form.

____

Signature of Patient or Legal Guardian Date

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BROKEN APPOINTMENT POLICY

At Lifetime Health & Wellness, it is our responsibility to provide our patients with excellent health care in a timely manner. As a service, we want to give care to as many patients as possible each day with minimal waiting time. We reserve your appointment time to achieve that goal. Because of this, we require a notice for missed appointments.

For appointments that are forgotten or willfully missed, it is our policy to charge for these appointments. We understand that people get sick, cars break down, etc. and will take that into account. No show appointments or appointments cancelled with less than 3 hours notice will be charged $20.00 (You may leave a voice mail message if our office is closed.)

YOUR INSURANCE COMPANY IS NOT RESPONSIBLE FOR PAYING FOR MISSED APPOINTMENTS.

Thank you for your respect of our policy and other patients. By signing this, I agree to the cancellation terms of this office.

Date: ______________________________

Name ______________________________ Signature: ______________________________
(Please Print)

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Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by C.E.O. Westminster for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by C.E.O. Westminster may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. C.E.O. Westminster is not required to agree to the restrictions that I may request. However, if C.E.O. Westminster agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that C.E.O. Westminster has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of C.E.O. Westminster. I understand that I have a legal right to review C.E.O. Westminster's Notice of Privacy Practices before I sign this consent and we encourage you to read it in full. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations at our clinic. The Notice of Privacy Practices for C.E.O. Westminster is also posted in the waiting room at 8155 W. 94th Avenue Broomfield, CO 80021.

C.E.O. Westminster's Notice of Privacy Practices is subject to change. I may obtain a revised notice of privacy practices by calling our clinic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

________________________________ ________________________________
Signature of Patient or Personal Representative Printed Name of Patient

___________________________ ____________________________________
Date of Signing Description of Personal Representative's Authority